STATUTORY AUTHORITY: 22 M.R.S.A., §8708-A, Chapter 270

- **Nursing-Sensitive Patient-Centered (NSPC) Health Care Quality Data Set**
- **Nursing-Sensitive System-Centered (NSSC) Health Care Quality Data Set**

Data Collection and Reporting Instructions

In accordance with the above statutory authority, the following instructions are applicable to all Maine Hospitals.

For all patients listed in the specific denominator and numerator categories (minus exclusions) listed in the NQF National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set, A Consensus Report, 2004, each hospital or their agent shall report data to the Maine Health Data Organization (MHDO) for the following patient-centered outcome quality metrics:

For each nursing-sensitive patient-centered (NSPC) health care outcome measure, the NSPC metrics are:

NSPC – 1: Percentage of inpatients who have a hospital-acquired pressure ulcer (Stage 1 or greater).

NSPC – 2: Number of inpatient falls per inpatient days.

NSPC – 3: Number of inpatient falls with injuries per inpatient days.

NSPC – 4: Percentage of inpatients who have a vest or limb restraint.

For the total number of productive hours worked by the nursing staff (RN, LPN, UAP) with direct patient care responsibilities as identified in the specific

denominator and numerator categories (minus exclusions) listed in the NQF National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set, A Consensus Report, 2004, for the following nursing system-centered health care metrics:

For each nursing-sensitive system-centered (NSSC) health care measure, the NSSC Skill Mix metrics are:

NSSC – 1: Percentage of RN care hours to total nursing care hours.

NSSC – 2: Percentage of LPN care hours to total nursing care hours.

NSSC – 3: Percentage of UAP care hours to total nursing care hours.

NSSC – 4: Percentage of contract care hours (RN, LPN, and UAP) to total nursing care hours.

For each nursing-sensitive system-centered (NSSC) health care measure, the NSSC nursing care hours metrics are:

NSSC – 5: Number of RN care hours per inpatient day.

NSSC – 6: Number of nursing care hours (RN, LPN, UAP) per inpatient day.

NSSC – 7a: Number of voluntary uncontrolled separations (RNs/advanced practice nurses) during the quarter.

NSSC – 7b: Number of voluntary uncontrolled separations (LPNs/nurse'sassistants/aides) during the quarter.

INSTRUCTIONS

DATA SPECIFICATIONS

NSPC – 1: Percentage of inpatients who have a hospital-acquired pressure ulcer (Stage I or greater).

Numerator: Inpatients with a National Pressure Ulcer Advisory Panel (NPUAP)

Stage I or greater (I – IV + eschar) hospital-acquired pressure ulcer.

Denominator: The total number of inpatients in the prevalence study.

Exclusions:

- Skin breakdown due to arterial occlusion, venous insufficiency, diabetes neuropathy, or incontinence dermatitis is not reported in the numerator
- Pressure ulcers present on admission (community acquired)
- Pressure ulcers discovered/documented on first day of hospitalization
- If the prevalence study is done on the first day of a patient's hospital stay and the patient's ulcer is already present
- If the prevalence study is done on the second day of a patient's hospital stay and the patient's Stage II+ ulcer is already present

Go to NSPC – 1 Frequently Asked Questions (FAQs)

NSPC – 2: Number of inpatient falls per inpatient days.

Numerator: Number of inpatient falls x 1,000

Denominator: Total number of inpatient days.

Exclusions: None

Go to NSPC – 2 Frequently Asked Questions (FAQs)

NSPC – 3: Number of inpatient falls with injuries per inpatient days.

Numerator: Number of inpatient falls with injuries x 1,000

Denominator: Total number of inpatient days.

Exclusions: None

Go to NSPC – 3 Frequently Asked Questions (FAQs)

NSPC – 4: Percentage inpatients who have a vest or limb restraint.

Numerator: Inpatients who have vest restraint and/or limb restraint (upper or lower or both) on the day of the prevalence study.

Denominator: The total number of inpatients in the prevalence study.

Exclusions: None

Go to NSPC – 4 Frequently Asked Questions (FAQs)

NSSC – 1: Percentage of RN care hours to total nursing care hours.

Numerator: Number of productive hours worked by RN nursing staff (employee and contract) with direct patient care responsibilities.

Denominator: Number of total productive hours worked by RN, LPN, and UAP nursing staff (employee and contract) with direct patient care responsibilities.

Exclusions: None

Go to NSSC – 1 Frequently Asked Questions (FAQs)

NSSC – 2: Percentage of LPN care hours to total nursing care hours.

Numerator: Number of productive hours worked by LPN nursing staff (employee and contract) with direct patient care responsibilities.

Denominator: Number of total productive hours worked by RN, LPN, and UAP nursing staff (employee and contract) with direct patient care responsibilities.

Exclusions: None

Go to NSSC – 2 Frequently Asked Questions (FAQs)

NSSC – 3: Percentage of UAP care hours to total nursing care hours.

Numerator: Number of productive hours worked by UAP staff (employee and contract) with direct patient care responsibilities.

Denominator: Number of total productive hours worked by RN, LPN, and UAP nursing staff (employee and contract) with direct patient care responsibilities.

Exclusions: None

Go to NSSC – 3 Frequently Asked Questions (FAQs)

NSSC – 4: Percentage of contract care hours (RN, LPN, and UAP) to total nursing care hours.

Numerator: Number of productive hours worked by

contract staff (RN, LPN, and UAP) with direct patient care responsibilities.

Denominator: **Number of total productive hours worked by RN, LPN, and UAP nursing staff (employee and contract) with direct patient care responsibilities.**

Exclusions: **None**

Go to NSSC – 4 Frequently Asked Questions (FAQs)

NSSC – 5: **Number of RN care hours per inpatient day.**

Numerator: **Number of productive hours worked by RN nursing staff with direct patient care responsibilities.**

Denominator: **Inpatient Days**

Exclusions: **None**

NSSC – 6: **Number of productive hours worked by nursing staff (RN, LPN, UAP), employee and contract, per inpatient day.**

Numerator: **Number of productive hours worked by nursing staff (RN, LPN, and UAP), employee and contract, with direct patient care responsibilities.**

Denominator: **Inpatient Days**

Exclusions: **None**

NSSC – 7a: Number of voluntary uncontrolled separations during the quarter for RNs and advanced practice nurses

Numerator: Number of voluntary uncontrolled separations for RNs and advanced practice nurses that were employed on the first day of the quarter.

Denominator: Number of RNs and advanced practice nurses (full time plus part time) employed on the first day of the quarter.

NSSC – 7b: Number of voluntary uncontrolled separations during the quarter for LPNs and nurses's assistants/aides

Numerator: Number of voluntary uncontrolled separations for LPNs and nurses's assistants/aides that were employed on the first day of the quarter.

Denominator: Number of LPNs and nurse's assistants/aides (full time plus part time) employed on the first day of the quarter.

Exclusions:

- **Separations due to death, illness, pregnancy, relocation, retirement, performance or discipline, cutbacks due to mergers, cyclical layoffs, permanent reductions in force, intramural transfers (i.e., unit to unit), and internal promotions.**
- **Per diem consultants, temporary, agency, non-salaried physicians, students in training.**

Go to NSSC – 7 Frequently Asked Questions (FAQs)

NSPC – 1: Percentage of inpatients who have a hospital-acquired pressure ulcer (Stage 2 or greater).

FREQUENTLY ASKED QUESTIONS

1. Do we have to identify every patient with a pressure ulcer of Stage I or greater during the reporting period?

You are not required to identify every patient with a Stage I or greater hospital-acquired pressure ulcer during any given reporting period. You should conduct a prevalence study once during each reporting period to determine the prevalence of these ulcers in your inpatient population.

We haven't done prevalence studies in the past. How should I prepare for and conduct one?

The following procedure is has been suggested by the National Pressure Ulcer Advisory Panel (NPUAP) but, in general terms, its process is applicable to any prevalence study, including one required under these rules to assess the prevalence of restraint use:

A pilot study of the patient data collection process should be conducted 1 month before the audit date. The purpose of the pilot is to test the feasibility of the data collection process, to clarify training curriculum content, and to make adjustments to the study protocol as needed. Audit leaders familiar with the study procedures and skilled at skin and wound assessment might conduct the pilot on an adult surgical unit.

Teams of trained personnel should collect data for the audit. Each team might consist of 3 persons from selected and volunteer multidisciplinary staff members. The roles of the team members might include leader, assistant, and data recorder. One week before the study date, all study personnel should participate in a mandatory training session provided by the audit leader(s). Training might include: audit method, identification and staging of pressure ulcers, and review of the data collection tool. Study personnel should be instructed on the need to consistently apply the NPUAP Staging System when staging the ulcers and to grade wounds obscured with eschar as "unable to stage." To assess accuracy in application of the NPUAP Staging System and to establish interrater agreement, study personnel should complete a pressure ulcer staging recognition test at the conclusion of the training session.

Information sessions should be provided throughout the hospital to inform staff about the purpose of the audit, the procedure that will be used, and the involvement of the staff on audit day. The audit leader(s) might conduct the

information sessions at administrative meetings, unit meetings, and staff inservice sessions.

For the purposes of this rule, the audit day shall occur on any Tuesday, Wednesday, or Thursday within the second month of the quarter. During an 8-hour period on audit day, each data collection team should perform head-to-toe skin assessments on all inpatients on the unit on that day. To ensure the skin surfaces that needed to be examined are adequately exposed, patients should be turned and dressings, splints, and casts should be removed where appropriate. Special wound dressings that can not be removed should be left intact, and the wound should be documented as "unable to stage." The assistance of unit staff members should be enlisted wherever necessary. Wound, ostomy, and continence (WOC) nurses specializing in wound management, if available in the hospital, should be available throughout the audit period to confirm wound staging whenever an audit team is unable to come to consensus. Measures to ensure patient safety, privacy, and anonymity should be taken throughout the survey.

An information sheet explaining the purpose and patient contribution to the audit should be distributed to all inpatients the day before the survey. No formal written informed consent from each patient is necessary, because no risks to the patient are anticipated. Additionally, unit staff understands that skin assessment is part of routine nursing care. Permission to conduct the audit should be received from the appropriate hospital and/or medical staff committee(s). On audit day, whenever possible, verbal consent should be obtained from patients or family members. Patients who choose not to participate should not be assessed. Body surfaces of patients who are cognitively impaired should be assessed as part of routine nursing assessment and their unit staff.

3. Should we include patients admitted for "observation" as inpatients when collecting this data?

Yes. Anyone on the unit at the time of the prevalence study should be included.

4. Should we include patients in the Emergency Department or patients in "holding areas" awaiting admission when collecting this data?

No. They are not on the unit.

5. Are there any clinically-related exclusion criteria, e.g. patients with paraplegia or quadriplegia for whom pressure ulcers are quite prevalent?

The only clinical exception to the numerator data is: "Skin breakdown due to arterial occlusion, venous insufficiency, diabetes neuropathy, or incontinence dermatitis".

6. If a patient has been in the hospital for several days or weeks, and a Stage I or greater pressure ulcer was identified in the admission assessment, should we count that patient in the numerator as part of this data collection process?

No. If a Stage II or greater pressure ulcer is noted in the admission assessment, it is considered to be "community acquired" and should not be counted in the numerator.

NSPC – 2: Number of inpatient falls per inpatient days.

FREQUENTLY ASKED QUESTIONS

1. Which method of data collection is recommended for this metric?

Data for this metric should be derived from internal reports of falls, i.e. "incident reports", "event reports", quality and/or safety reports). Because those reports are dependent upon your organization's policy on event reporting (specifically, falls) policies and upon the staff compliance with those policies, it may be beneficial to review your policy(ies) and to compare them to the definition for "falls" and fall-associated injuries used by the National Quality Forum in validating this metric. In addition, it may be helpful to review these polices with your staff to make certain that they understand the definitions of reportable events and the importance of reporting them.

2. If a patient falls but has no injury as a result of the fall, should that event be included in the numerator?

NSPC -2 requires that you include all falls in the numerator. Any fall, whether or not the patient was injured, must be included here.

3. A nurse is assisting a post-operative patient with ambulation, the patient becomes weak, and the nurse assists the patient to the floor. Should that sort of event be documented as a fall?

Yes. Consistent with ANA all falls are recorded. This is considered an assisted fall by ANA definition.

4. If a family member or non-clinical hospital staff member reports that a patient has fallen, but the patient has no sign of injury and the fall cannot be validated, should that report be counted as a fall and included in the numerator?

In the case of a reported fall that was not witnessed by a clinician, it is assumed that the patient's nurse would appropriately document that report in the patient's record and include that information in future nursing assessments and care planning. Given the potential importance of such a report, it should be reported as a fall through the designated organizational reporting process and included in the numerator for the purpose of data collection for this metric.

5. We have a patient admitted to our unit who has a long history of falling frequently at home and she is now admitted for diagnostic testing to determine the possible etiology of her falls. Since frequent falling is the basis for her admission, should she be counted in the denominator?

Yes. There are no denominator exclusions for this metric.

NSPC – 3: Number of inpatient falls with injuries per inpatient days.

FREQUENTLY ASKED QUESTIONS

1. Why are we required to include falls with very minor injuries in the numerator?

Because the frequency of patient falls has been demonstrated to be a nursing-sensitive metric, it is important to capture all falls, regardless of the severity of injury. Patient falls rates are related to a number of nursing practice issues. By collecting fall frequency data and relating it to patient injuries, your organization will be better able to assess risk and consider

alternative solutions to impact both fall prevention and potential environmental factors that may be related to fall injuries.

2. If a patient falls and sustains an injury but refused treatment, should we include that fall in the numerator?

Yes. The inclusion criterion states that an injury that "requires clinical intervention" must be included in the numerator. When a clinician assesses a fall-related injury and determines that clinical intervention is required, the injury is assumed to have occurred whether or not the patient consents to the recommended intervention.

3. If a patient fall with injury is reported but the clinical intervention is not included in the report, how do we determine the severity of injury?

Although it may important to your organization's internal patient safety analysis, for the purpose of reporting data under this authority, you are not required to indicate the level of severity of the fall. If a patient incurs any injury in which clinical intervention is required, the fall should be included in the numerator data for this metric. If there is not documentation of clinical intervention, the data analyst should make a reasonable assumption based upon the documentation of the fall and the reported resulting injury.

NSPC – 4: Percentage inpatients who have a vest or limb restraint.

FREQUENTLY ASKED QUESTIONS

1. Do we have to identify every patient with a vest or limb restraint during the reporting period?

You are not required to identify every patient with a vest or limb restraint during any given reporting period. You should conduct a prevalence study once during each reporting period to determine the prevalence of the use of vest and/or limb restraints in your inpatient population.

2. We haven't done prevalence studies in the past. How should I prepare for and conduct one?

To review a suggested model for conducting a prevalence study, see NSPC-1, Frequently Asked Question #2.

3. Is an arm board affixed to a patient for the purpose of maintaining position and patency of a vascular access catheter considered a restraint?

No. If the purpose of the device is to maintain positional patency of vascular access the arm board is not considered restraint. If, however, the purpose of an arm board is to prevent the patient from pulling on or otherwise disrupting the access device, it is considered restraint.

4. A patient has a "halo" brace applied to permit greater freedom of movement following a cervical spine injury. Is the halo considered to be a restraint?

No. A voluntary mechanical support used to achieve proper body position, balance, or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support is not considered a restraint. For further information on interpretive guidelines for exceptions to the definition of restraints see definitions.

5. An inpatient is under police custody and is in handcuffs. Should we count the handcuffs as restraints for the purposes of data collection for this metric?

No. See "Restraint Exceptions" in definitions.

NSSC – 1: Percentage of RN care hours to total nursing care hours.

FREQUENTLY ASKED QUESTIONS

1. In addition to her administrative responsibilities, our Nurse Manager assists nurses with patient care responsibilities as needed throughout the day. Should her hours be included in the numerator calculation?

The role of the Nurse Manager varies significantly from one hospital to another, particularly from smaller hospitals to larger ones. If the Nurse Manager's job description clearly identifies an expectation that the individual will devote a minimum of 50% of his/her productive hours to patient care responsibilities, the Nurse Manager's productive hours should be added to the numerator.

2. We have both a Clinical Nurse Specialist and Nurse Practitioner on staff in our nursing unit. Should their hours be included in the numerator calculation?

Typically, Advanced Practice Nurses provide an additional patient care resource that is available to the unit staff, but are not considered part of the daily nursing care staffing pattern. Their hours should not be included in either the numerator or the denominator.

3. We have three RNs who work as an "IV Team". How should we count their hours?

Nurses practicing on "IV Teams" or other similar expert resource teams typically provide an additional level of specialized clinical expertise in support of the staff nurse. As with Advanced Practice Nurses, the hours of nurses practicing on expert resource teams should not be included in either the numerator or the denominator.

4. There are RNs who work in our Radiology Department. How do we account for their hours?

Although nurses practicing in diagnostic services areas may provide nursing care to inpatients, they are not part of the unit nursing staff, and their role is typically not considered when nurse staffing plans are prepared. The hours of these nurses should not be included in either the numerator or the denominator.

5. Should we report this information on a unit-by-unit basis, or are we expected to submit data for the entire hospital as one number?

Data should be aggregated and reported by individual hospital units. See Appendix B, Eligible Unit Type Table.

6. Nursing staff frequently leave the unit for short periods of time to attend training or participate in other administrative functions. What is the smallest period of time which must be tracked (subtracted from direct patient care hours).

Any absence from the unit of less than or equal to an hour need not be subtracted from direct patient care hours. Any absence of more than one hour should be subtracted from the unit's direct patient care hours unless replaced by another staff member (replacement staff hours are then counted towards the unit total).

NSSC – 2: Percentage of LPN care hours to total nursing care hours.

FREQUENTLY ASKED QUESTIONS

1. Our hospital does not permit LPN practice in the acute inpatient setting. We do, however, have a number of LPNs who are practicing at a level similar to that of a CNA on the acute inpatient unit. How do we account for their hours?

For the purpose of assessing hospital staffing ratios and skill mix, all individuals on the inpatient nursing staff who have patient care responsibilities and who are LPNs in accordance with the definition provided in this document should be counted in the numerator and denominator for this metric.

NSSC – 3: Percentage of UAP care hours to total nursing care hours.

FREQUENTLY ASKED QUESTIONS

1. We have EMTs (Basic, Intermediate, and Paramedic) who assist on the inpatient nursing units. Are these EMS personnel considered UAPs for the purposes of this metric?

EMS personnel must be considered UAPs and should be counted in both the numerator and denominator, if they have patient care responsibilities and are part of the staffing plan for any inpatient area.

2. In our nursery, we have volunteers who frequently come in to assist with feeding the newborns. Are they considered UAPs for the purpose of this metric?

No. Volunteers are typically not considered part of the staffing plan for an inpatient unit.

NSSC – 4: Percentage of contract hours (RN, LPN, and UAP) to total nursing care hours.

FREQUENTLY ASKED QUESTIONS

1. We have a number of nurses who work on a "Per Diem" basis ("PRN Nurses, etc.). Do we count them as "contract" nurses or as employees?

Nurses (RNs and LPNs) and UAPs who are employed by the hospital, whether full time, part time, or a "per diem" or "per shift" basis are to be counted as employees. If the nurse or UAP is paid directly by the hospital, (s)he is an employee. If the hospital pays a third party (agency) or has engaged the nurse or UAP through a time-limited contract with an agency, the nurse or UAP is "contracted".

2. We have a nurse who is here under contract, but the contract is for one year. Do we count her as an employee or as a contracted nurse?

See above. The key to the decision regarding where to allocate the hours is directly linked to the existence of a contract or payment to a third party (agency). The length of a contract does not alter the individual's status as a contractor.

NSSC – 7a: **Number of voluntary uncontrolled separations during the quarter for RNs and advanced practice nurses.**

NSSC – 7b: **Number of voluntary uncontrolled separations during the quarter for LPNs and nurse's assistants/aides.**

FREQUENTLY ASKED QUESTIONS

1. We have a number of staff (nurses and others) on our employee roster who work on a per diem basis. Do we count them in the denominator of number of employees for the calculation for this metric?

If they are employed by the hospital (not contract staff) and are full time or part time employees, then they should be counted in the denominator regardless of whether they are "per diem" or "per shift" staff.

2. Should we include full time or part time nursing staff who are on leave of absence in the denominator?

Yes. As long a member of the nursing staff who is on leave of absence, for any reason, is still considered by the organization to be a full time or part time employee, the position should be included in the total number of nursing employees.

3. If we have a nursing staff member who has been suspended for disciplinary reasons, should we count that position in the denominator?

Yes. As long a nursing staff member who has been suspended is still considered by the organization to be a full time or part time employee, the position should be included in the total number of employees.

4. How do we account for "traveler" (contract) nurses who have left the organization because their contracts expired?

Temporary or agency-contracted nursing staff, if not employees of the hospital during their tenure on the staff, are not included in the denominator.

ADDITIONAL REGULATORY INFORMATION

Submission Requirements.

1. Filing Media. Each hospital or their agent shall file all applicable data sets on diskette, compact disc, or via electronic transmission provided that such diskette, compact disc, or electronic transmission is compatible with the data processing capabilities of the MHDO.

2. File Submission. All data file submissions shall be accompanied by an electronic or a hard copy transmittal sheet containing the following information: identification of the health care facility, file name, data period(s) (quarter/year), date sent, and a contact person with telephone number and E-mail address. The transmittal sheet layout is presented as Appendix A.

3. Filing Periods. Data generated in accordance with the provisions of Sections 2, 3, and 4 shall be submitted within 30 calendar days after the 4th month following the end of each calendar quarter in which the service occurred. The filing periods are as follows:

1st Quarter	**January, February, March**	**August 30th**
2nd Quarter	**April, May, June**	**November 30th**
3rd Quarter	**July, August, September**	**March 2nd**
4th Quarter	**October, November, December**	**May 30th**

Standards for Data; Notification; Response.

1. Standards. The MHDO or its designee shall evaluate each file submission in accordance with the following standards:

2. For each category of metrics, hospitals shall report each numerator (metric) and denominator (population) as defined in the most current version of the metrics as endorsed in the NQF National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set, A Consensus Report, 2004, for each Nursing Sensitive Health Care Measure.

3. Coding values indicating "data not available", "data unknown", or the equivalent will not be accepted.

4. Notification. Upon completion of this evaluation, the MHDO will promptly notify each hospital and ambulatory surgery facility whose data submissions do not satisfy the standards for any filing period. This notification will identify the specific file and the data elements within them that do not satisfy the standards.

5. Resubmission. Each hospital and ambulatory surgery facility notified under subsection 6. B. will resubmit the data within 30 days of the notification by making the necessary changes to satisfy the standards.

Public Access.

Information collected, processed and/or analyzed under this rule shall be subject to release to the public or retained as confidential information in accordance with 22 M.R.S.A. § 8707 and Code of Maine Rules 90-590, Chapter 120: Release of Information to the Public, unless prohibited by state or federal law.

Waivers to Data Submission Requirements.

If a hospital or ambulatory surgery facility due to circumstances beyond its control is temporarily unable to meet the terms and conditions of this Chapter, a written request must be made to the Executive Director of the MHDO as soon as it is practicable after the hospital has determined that an extension is required. The written request shall include: the specific requirement to be waived; an explanation of the cause; the methodology proposed to eliminate the necessity of the waiver; and the time frame required to come into compliance. The Executive Director shall present the request to the MHDO Board at its next regularly scheduled meeting where the request shall be approved or denied.

Compliance.

The failure to file, report, or correct quality data in accordance with the provisions of this Chapter may be considered a violation under 22 MRSA Sec. 8705-A.

Implementation.

Hospitals and ambulatory surgery facilities or their agent shall construct health care quality data files in accordance with the specifications, formats, and codes as described in above Sections. The initial filing data shall be no later than May 30th, 2006 for data generated in October, November, and December of 2005.

DEFINITIONS

"Advanced Practice Nurse"

Advanced practice registered nursing. "Advanced practice registered nursing" (A.P.R.N.) means the practice of a registered professional nurse who, on the basis of specialized education and experience, is authorized under Maine Board of Nursing rules to deliver expanded professional health care.

"ANA-NDNQI"

The National Database of Nursing Quality Indicators (NDNQI), a repository for nursing-sensitive indicators, is a program of the American Nurses Association (ANA). The project is administered on ANA's behalf by The University of Kansas School of Nursing.

"CaINOC"

The California Nursing Outcomes Coalition (CalNOC) project is an initiative that has become the largest ongoing nursing quality measurement repository in the nation. Launched in 1996 by California nursing leaders concerned with trends in hospital care, CalNOC has created reliable quality benchmark data to define patient safety thresholds in California.

"Care Hours [i]"

The number of actual hours worked by employed and contracted RNs, LPNs, and/or UAPs, with direct patient care responsibilities, not budgeted or scheduled hours. Care hours do not include vacation, medical leave, orientation, educational leave, or committee time.

"Contract Hours [ii]"

Contracted and/or agency staff who are not employed by the facility but are hired on a contractual basis to fill staffing needs for a designated shift or for a short-term contracted basis, or registry staff from outside the facility, or traveling nurse staff contracted to the facility for a designated period of time.

"Direct Patient Care Responsibility"

Patient-centered nursing activities carried out by unit-based staff in the presence of the patient (e.g., medication administration, nursing treatments, nursing rounds, admission/transfer/discharge, patient teaching, patient communication) and nursing activities that occur away from the patient that are patient related (e.g., coordination of patient care, documentation, treatment, planning).

"Fall [iii]"

An unplanned descent to the floor (or extension of the floor, e.g. trash can/equipment) with or without injury to the patient, and occurs on an eligible reporting unit. All types of falls are included whether a result of physiological reasons (e.g. fainting) or environmental reasons (e.g. slippery floor). Include assisted falls (when a staff member attempts to minimize the impact of a fall by easing patient's descent to the floor or in some manner attempting to break the patient's fall).

"Hospital [iv]"

Any acute care institution required to be licensed pursuant to 22 MRSA, chapter 405.

"Hospital Acquired Pressure Ulcer"

A pressure ulcer identified during the prevalence study which was not documented on admission.

"Inpatient" *(as defined by Centers for Medicare & Medicaid Services)*

A person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. See Medicare Benefit Policy Manual for further clarification. http://www.cms.hhs.gov/manuals/102_policy/bp102c01.pdf For these purposes, patients on the unit at the time of the prevalence study (e.g., short stay, observation, same day surgery, or swing beds) will be included in the prevalence study.

"Inpatient days [v]"

The total number of days of admission for all patients admitted during an identified time period. A patient day is 24 hours beginning on the hour of admission. The total number of inpatient days for each unit is reported for each quarter including "days" of care provided to short stay, observation, same day surgery, or swing bed patients. You may exclude these short stay patient hours from inpatient days only if you can reliably identify nursing care hours associated with those beds and subtract them from the total productive nursing care hours for that unit. Acceptable methods for collecting inpatient day data include (the requirement is to default to the method that provides the greatest level of detail within the capabilities of the current system):

Midnight Census

- This is adequate for units that have all inpatient admissions. It is the least accurate method for units that have both inpatient and short stay patients. The daily number should be summed for every day in the quarter.

Midnight Census Plus Patient Days from Actual Hours for Short Stay Patients

- This is an accurate method for units that have both inpatients and short stay patients. The short stay "days" should be reported separately from midnight census and added to obtain patient days. The total daily hours for short stay patients should be summed for the quarter and divided by 24.

Midnight Census Plus Patient Days from Average Hours for Short Stay Patients

- This method is not as accurate as using a count of short stay patient hours on units that have both inpatients and short stay patients. The short stay average is to be obtained from a special study documenting the time spent by short stay patients on specific unit types. Average short stay days should be reported

separately and are added to midnight census to obtain patient days. The average daily hours should be multiplied by the number of days in the quarter and the product divided by 24 to produce average short stay days.

Patient Days from Actual Hours

- This is the most accurate method. An increasing number of facilities have accounting systems that track the actual time spent in the facility by each patient. Sum actual hours for all patients, whether in patient or short stay, and divide by 24.

Patient Days Averaged from Multiple Census Reports

- Some facilities collect censuses multiple times per day (e.g., every four hours or each shift). This method is more accurate than the Midnight Census, but not as accurate as Midnight Census Plus Actual Short Stay Hours or as Actual Patient Hours. A sum of the daily average censuses can be calculated to determine patient days for the quarter on the unit.

"Injury"

An event which requires clinical intervention at any of the following levels: minor (results in application of a dressing, ice, cleaning of a wound, limb elevation, or topical medication), moderate (results in suturing, steri-strips, fracture, or splinting), major (results in surgery, casting, or traction), or death (as a result of the fall).

"LPN [vi]" Licensed Practical Nurse

An individual who is currently licensed as a "licensed practical nurse" pursuant to 32 MRSA, chapter 31.

"MRSA"

Maine Revised Statutes Annotated

"Nursing Care Hours [vii]"

The number of actual hours worked by employed and contracted RNs, LPNs, and/or UAPs, with direct patient care responsibilities, not budgeted or scheduled hours.

Nursing care hours do not include vacation, medical leave, orientation, educational leave, or committee time.

"Pressure Ulcer [viii]"

Any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers are usually located over bony prominences and are graded or staged to classify the degree of tissue damage observed. Such staging is used as a tool for communication and assessment. The recommendations regarding staging ... are consistent with those of the National Pressure Ulcer Advisory Panel (Cuddigan, et. al., 2001), as derived from National Pressure Ulcer Advisory Panel Consensus Development Conference (NPUAP, 1989) and previous staging systems proposed by SHEA (1975) and the Wound Ostomy and Continence Nurses Society (WOCN) (International Association of Enterostomal Therapy, 1988). Numerical identification of stages does not necessarily imply a progression in ulcer severity. For example, a Stage I ulcer may have very little tissue damage or it may have necrotic underlying tissue, because muscle tissue is more sensitive than skin to pressure-induced ischemia.

Pressure ulcers are staged as follows:

Stage I:

An observable pressure-related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as defined area of persistent redness in light pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage II:

Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage III:

Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage IV:

Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with this stage.

Non-Stagable:

When necrotic tissue is present a pressure ulcer cannot be accurately staged until the necrotic tissue is removed. Dark purple or bruised areas, over bony prominences with intact skin may indicate deeper tissue damage. In addition, there may be situations in which an ulcer is located under a device, like a cast, and it cannot be visualized during the survey.

"Prevalence Study [ix]"

A prevalence study is the measure of a specific condition in a specific population at a given point in time. It is defined by the formula: the number of existing cases at a given point in time divided by the population under study at that given point in time.

"Productive Hours"

The actual hours paid for direct patient care work, not budgeted or scheduled hours. Productive hours do not include vacation, medical leave, orientation, education leave, or committee time.

"Restraint"

Any manual method or physical or mechanical device, material, or equipment attached to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

"Restraint Exceptions"

For the purposes of this study, this definition will not include restraint use that is only associated with medical, dental, diagnostic, or surgical procedures and is based on standard practice for the procedure (sometimes referred to as "treatment restraints"); seclusion; restraint uses that are forensic or correctional restrictions used for security purposes unrelated to clinical care; and devices used to meet the assessed needs of a patient who requires adaptive support or a medical protective device that does not restrict patient motion needed for activities of daily living.

"RN [x]" Registered Nurse

An individual who is currently licensed as a "Registered Professional Nurse" pursuant to 32 MRSA, chapter 31.

"Swing Bed"

A bed in a hospital, that is permitted to use its beds, as needed, to provide either acute care or skilled nursing facility-level services.

"Time Period"

For the purpose of data collection and reporting under these rules, the following time periods shall apply for each metric:

METRIC	TIME PERIOD
NSPC – 1: Percentage of inpatients who have a hospital-acquired pressure ulcer (Stage 2 or greater).	The day of the prevalence study conducted once each quarter of a year (once every three months**). The study should occur on any Tuesday, Wednesday, or Thursday within the second month of the quarter.** The prevalence study should be completed in a single day (24 hours). See Filing Period requirements.
NSPC – 2: Number of inpatient falls per inpatient days.	Each quarter of a year (3 months). See Filing Period requirements.
NSPC – 3: Number of inpatient falls with injuries per inpatient days.	Each quarter of a year (3 months). See Filing Period requirements.
NSPC – 4: Percentage of inpatients who have a vest or limb restraint.	The day of the prevalence study conducted once each quarter of a year (once every three months). **The study should occur on any Tuesday, Wednesday, or Thursday within the second month of the quarter.** The prevalence study should be completed in a single day (24 hours). See Filing Period requirements.
NSSC – 1: Percentage of RN care hours to total nursing care hours.	Each quarter of a year (3 months). See Filing Period requirements.
NSSC – 2: Percentage of LPN care hours to total nursing care hours.	Each quarter of a year (3 months). See Filing Period requirements.

NSSC – 3: Percentage of UAP care hours to total nursing care hours.	Each quarter of a year (3 months). See Filing Period requirements.
NSSC – 4: Percentage of contract hours (RN, LPN, and UAP) to total nursing care hours.	Each quarter of a year (3 months). See Filing Period requirements.
NSSC – 5: Number of RN care hours per inpatient day.	Each quarter of a year (3 months). See Filing Period requirements.
NSSC – 6: Number of nursing staff hours (RN, LPN, UAP) per inpatient day.	Each quarter of a year (3 months). See Filing Period requirements.
NSSC – 7: Number of voluntary uncontrolled separations during the quarter for RNs and advanced practice nurses, LPNs, and nurse's assistants/aides.	Each quarter of a year (3 months). See Filing Period requirements.

"UAP [xi]" Unlicensed Assistive Personnel

Individuals employed to provide hands-on assistance with activities of living to individuals in homes, assisted living centers, residential care facilities, hospitals, and other health settings pursuant to 22 MRSA, chapter 401. It includes certified nursing assistants and emergency medical technicians.

"Voluntary Uncontrolled Separation"

Termination of employment by resignation done willingly, of the employee's own accord and beyond the authority or power of the health care facility to hold in restraint. Exceptions include separations due to death, illness, pregnancy, relocation, retirement, performance or discipline, cutbacks due to mergers, cyclical layoffs, permanent reductions in force, intramural transfers (i.e., unit to unit), and internal promotions.

ENDNOTES

[i] National Quality Forum National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set Appendix A – Specifications of the National Voluntary Consensus Standards for Nursing-Sensitive Care 2004: American Nurses Association, National Database of Nursing Quality Indicators: *Guidelines for Data Collection and Submission on Quarterly Indicators.*

[ii] National Quality Forum National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set Appendix A – Specifications of the National Voluntary Consensus Standards for Nursing-Sensitive Care 2004: American Nurses Association, National Database of Nursing Quality Indicators: *Guidelines for Data Collection and Submission on Quarterly Indicators.*

[iii] National Quality Forum National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set Appendix A – Specifications of the National Voluntary Consensus Standards for Nursing-Sensitive Care 2004: American Nurses Association, National Database of Nursing Quality Indicators: *Guidelines for Data Collection and Submission on Quarterly Indicators.*

[iv] 90-590 MAINE HEALTH DATA ORGANIZATION Chapter 270: UNIFORM REPORTING SYSTEM FOR QUALITY DATA SETS, Section 1. Definitions

[v] National Quality Forum National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set Appendix A – Specifications of the National Voluntary Consensus Standards for Nursing-Sensitive Care 2004: American Nurses Association, National Database of Nursing Quality Indicators: *Guidelines for Data Collection and Submission on Quarterly Indicators.*

[vi] 90-590 MAINE HEALTH DATA ORGANIZATION Chapter 270: UNIFORM REPORTING SYSTEM FOR QUALITY DATA SETS, Section 1. Definitions

[vii] National Quality Forum National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set Appendix A – Specifications of the National Voluntary Consensus Standards for Nursing-Sensitive Care 2004: American Nurses Association, National Database of Nursing Quality Indicators: *Guidelines for Data Collection and Submission on Quarterly Indicators.*

[viii] NPUAP/AHCPR classification (any lesion caused by unrelieved pressure resulting in the damage of underlying tissue); In Pressure Ulcers in Adults: Prediction and Prevention. Clinical Practice Guideline Number 3. AHCPR Pub. No. 92-0047; May 1992.

[ix] Last, John M. 2001. A Dictionary of Epidemiology, 4th ed, R. A. Spasoff, S.S. Harris and M.C. Thuriaux eds. Oxford: Oxford University Press

[x] 90-590 MAINE HEALTH DATA ORGANIZATION Chapter 270: UNIFORM REPORTING SYSTEM FOR QUALITY DATA SETS, Section 1. Definitions

[xi] 90-590 MAINE HEALTH DATA ORGANIZATION Chapter 270: UNIFORM REPORTING SYSTEM FOR QUALITY DATA SETS, Section 1. Definitions

Appendix A

Transmittal Sheet

Header Information:			
Identification of Hospital/ (Name):			
Hospital Unit (Type):			
Data Period (Quarter/Year):			
Date Sent (xx/xx/xxxx):			
Contact Person (Name, Address, Telephone, Fax, E-mail Address):			
Metric Identifier*:	**Numerator (Metric)**	**Denominator**	
NSPC-1	Inpatients with Hospital Acquired Pressure Ulcers	Inpatients Present on Day of Prevalence Survey	
NSPC-2	Inpatient Falls per Quarter	Inpatient Days Per Quarter	
NSPC-3	Inpatient Falls with Injury per Quarter	Inpatient Days Per Quarter	
NSPC-4	Inpatients with Vest or Limb Restraint	Inpatients Present on Day of Prevalence Survey	
Metric Identifier*:	**Numerator (Metric)**	**Denominator**	
NSSC-1	Employee and Contract RN Care Hours per Quarter	Total Employee and Contract (RN, LPN, UAP) Nursing Care Hours per Quarter	
NSSC-2	Employee and Contract LPN Care Hours per Quarter	Total Employee and Contract (RN, LPN, UAP) Nursing Care Hours per Quarter	
NSSC-3	Employee and Contract UAP Care Hours per Quarter	Total Employee and Contract (RN, LPN, UAP) Nursing Care Hours per Quarter	
NSSC-4	Total Contract (RN, LPN, UAP) Nursing Care Hours per Quarter	Total Employee and Contract (RN, LPN, UAP) Nursing Care Hours per Quarter	
NSSC-5	Employee and Contract RN Care Hours per Quarter	Inpatient Days per Quarter	
NSSC-6	Total Employee and Contract (RN, LPN, UAP) Nursing Care Hours per Quarter	Inpatient Days per Quarter	

Metric Identifier*:	Numerator (Metric)	Denominator	
NSSC-7a	Voluntary Uncontrolled Separations by RNs & Advanced Practice Nurses that were employed on the first day of the quarter	Total Employee (Part Time and Full Time) RNs & Advanced Practice Nurses on First Day of the Quarter	
NSSC-7b	Voluntary Uncontrolled Separations by LPNs & UAPs that were employed on the first day of the Quarter	Total Employee (Part Time and Full Time) LPNs & UAPs on First Day of the Quarter	
*For details refer to the NQF National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set, A Consensus Report as found at the MHDO website at http://mhdo.maine.gov/imhdo/			

Appendix B

Eligible Unit Type Table

Population and Unit Type Categories	Indicators				
	NSPC-1 **Hospital-Acquired Pressure Ulcer**	**NSPC-2, 3** **Falls and Falls with Injury**	**NSCP-4** **Vest or Limb Restraint**	**NSSC-1, 2, 3, 4, 5, 6** **Skill Mix and Care Hours Per Patient Day**	**NSSC-7** **Voluntary Uncontrolled Separations**
Critical Access Hospitals					
Mixed Acuity	X	X	X	X	X
Neonatal					
Level III/IV Critical Care				X	X
Level II Intermediate				X	X
Level I Continuing Care				X	X
Well Baby Nursery					X
Mixed Acuity					X
Pediatric					
Critical Care-Pediatric				X	X
Step Down				X	X
Medical				X	X
Surgical				X	X
Med-Surg Combined				X	X
Mixed Acuity- Swing Bed Hospital	X	X	X	X	X
Adult					
Critical Care-Adult	X	X	X	X	X
Step Down	X	X	X	X	X
Medical	X	X	X	X	X
Surgical	X	X	X	X	X
Med-Surg Combined	X	X	X	X	X
Obstetrics					X
Skilled Nursing Unit					X
Mixed Acuity- Swing Bed Hospital	X	X	X	X	X

Population and Unit Type Categories	Indicators				
	NSPC-1 **Hospital-Acquired Pressure Ulcer**	**NSPC-2, 3** **Falls and Falls with Injury**	**NSCP-4** **Vest or Limb Restraint**	**NSSC-1, 2, 3, 4, 5, 6** **Skill Mix and Care Hours Per Patient Day**	**NSSC-7** **Voluntary Uncontrolled Separations**
Psychiatric					
Adult				X	X
Adolescent				X	X
Child/Adolescent				X	X
Child				X	X
Geopsych				X	X
Behavioral Health				X	X
Specialty				X	X
Multiple Unit Types				X	X
Other Psychiatric Unit					X
Rehab					
Adult	X	X	X	X	X
Pediatric					X
Mixed Acuity- Swing Bed Hospital	X	X	X	X	X
Other					
Ambulatory Care					
Emergency Dept					
Intervention Unit					
Peri-operative					
Other Unit					